

VIRGINIA DEPARTMENT OF HEALTH MEANINGFUL USE REGISTRATION SYSTEM USER GUIDE AND CHECKLIST

Eligible Professionals

This document includes a user guide and checklist to assist eligible professionals (EP) in registering with the Virginia Department of Health (VDH) for Meaningful Use (MU) public health objectives. **VDH strongly recommends reviewing this entire document prior to starting the registration process.**

The **user guide** includes step-by-step directions to navigate you through the process of creating a user account and registering EPs in the VDH Meaningful Use Registration System.

The **checklist** outlines information needed by EPs to successfully complete a registration form in the VDH Meaningful Use Registration System.

The MU public health objectives available to EPs in Virginia are:

- Cancer Reporting
- Immunization
- Syndromic Surveillance

You can find additional resources regarding the onboarding process, transport options, contact information and message specifications for each objective on the VDH MU Website: <http://www.vdh.virginia.gov/clinicians/meaningfuluse>.

Please contact the VDH Meaningful Use Team (MeaningfulUse@vdh.virginia.gov) with questions or comments.



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User Enrollment

Helpful Hint

First Time Visiting the Website?

Click [Enroll Here](#) to create an account with the VDH MU Registration System.

Login:

Email Address:

Password:

[Forgot Password](#)

 **New User? [Enroll Here](#)**

USER ENROLLMENT

Email Address:*

Email Address will be used for account login.

Password:*

Password must be at least 8 characters long and have at least 1 number and 1 special character limited to "* = @ # \$ % ^ & "

Confirm Password:*

First Name:*

Middle Initial:

Last Name:*

Phone:*

Job Title:

Security Question:*

Security Answer:*

Comments:

Helpful Hint

Pay attention to the requirements in creating a password.

The security question can be whatever you want. Example security questions are:

1. What was your high school's mascot?
2. What street did you live on when you were 10?
3. What is your father's middle name?

Once you click **Submit**, you can login using your newly created password with your e-mail address.

* indicates a required field.

User Login

Helpful Hint
Returning to Website: Enter E-mail address and Password to Login to proceed into the MU Registration System.

Select [Forgot Password](#) if having issues logging in. You will have an opportunity to reset your password after answering a security question.

Login:
Email Address:
Password:

[Forgot Password](#)

New User? [Enroll Here](#)

User Portal

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

Virginia Department of Health - Meaningful Use Registration System

User Portal

User Portal [Change Password](#) | [Logout](#)

[New Hospital](#) | [New Practice \(Professionals\)](#)

Helpful Hint

Once logged into the MU Registration System, you can register an eligible professional at the User Portal. First, you must select "New Practice (Professionals)" to create a registration.

Practice Registration

Helpful Hint
Holding your mouse cursor over the question mark icon (?) will provide additional help information on each field. You can also refer to the checklist at the end of this document for additional, field-specific definitions.

Practice Information

Health Care System:* ⓘ Group NPI Number:

If Other Health Care System:

Incentive Program:* ⓘ

Practice Name:* ⓘ MU Stage:* ⓘ

Practice Type:* ⓘ Attestation Year:* ⓘ

If Other Practice Type:

Reporting Period Begin Date:* ⓘ Reporting Period End Date:* ⓘ

Helpful Hint
Check each box for the objective you intend to submit public health data.

Helpful Hint
Clicking the calendar icon will allow you to select a date.

Select Objectives

☐ Cancer Reporting ☐ Syndromic Surveillance ☐ Immunization

* indicates a required field.

Helpful Hint
Multiple Professionals for the same practice can be included in one registration if the following are the same:
MU Stage, Attestation Year, Reporting Period, Incentive Program, Objectives.
If any of these are different, a separate registration is needed.

Next

Exclusions

Select Objectives

☒ Cancer Reporting ☐ Syndromic Surveillance ☒ Immunization

Cancer
Do you diagnose or treat cancer?
Yes No

Vaccinations
Do you administer vaccinations?
Yes No

Helpful Hint
If either **Cancer Reporting** or **Immunization** are selected on the Practice Information screen, you will be prompted to answer questions about how you treat patients relating to that objective.
Yes will keep the objective selected.
No will unselect the objective for you. Contact MeaningfulUse@vdh.virginia.gov for official correspondence from VDH on your possibility to apply for an exclusion with Centers for Medicare and Medicaid for that objective.

Practice Location Information

Location Information

Location Name:*

City:*

Street:*

County/Independent City:*

Zip Code:*

State:*

Save

Helpful Hint

Enter the location of the first site of this practice in the top box and click **Save**.

A new row will appear in the bottom box allowing you to **edit** or **delete** the location if needed.

Continue to enter each physical location of the practice until all are listed in the bottom box and click **Next**.



Practice Locations

Atleast one Practice Location is required for registration.

* indicates a required field.

Back

Next

Practice Locations							
Edit	Delete	Name	Street	Zip Code	City	County/Independent City	State
		Test Practice	123 Main Street	22025	MONTCLAIR	PRINCE WILLIAM COUNTY	VA

* indicates a required field.

Helpful Hint

By entering the Zip Code, the City, County/Independent City and State will populate for you. If there is more than one city associated with a zip code, a pop up will appear asking you to select in which city the practice is physically located.

Please select the City where the facility is physically located

Zip Code	City	County	State
22025	DUMFRIES	PRINCE WILLIAM COUNTY	VA
22025	MONTCLAIR	PRINCE WILLIAM COUNTY	VA

Eligible Professional Information

Professional Information

First Name:*

Last Name:*

Middle Name:

NPI Number:*

Save

Helpful Hint

Enter the Name and NPI Number of the professional you are registering in the top box and click **Save**.

A new row will appear in the bottom box allowing you to **Edit** or **Delete** the professional if needed.

Continue to enter each professional of the practice until all are listed in the bottom box and click **Next**.

Eligible Professionals



Atleast one Eligible Professional is required for registration.

* indicates a required field.

Back

Next

Eligible Professionals

Edit	Delete	First Name	Last Name	Middle Name	NPI Number
		Test	Professional		0101212121

* indicates a required field.

Back

Next

Cancer Reporting Objective

Helpful Hint

The information on this screen should reflect the contact and vendor information only for the **Cancer Reporting** objective (though it may be the same as the other objectives).

Cancer Reporting:

Primary Organization Contact

Contact Name:*

Contact Role:*

Contact Email:*

Contact Phone:*

Contact Fax:

() - -

() - -

* Primary Organization Contact will be the individual who receives all official communication from VDH.

Technical Contact

Contact Name:

Contact Role:

Contact Email:

Contact Phone:

Contact Fax:

() - -

() - -

Helpful Hint

Primary Organization Contact (POC) is a required section. The POC will receive all official communication from VDH. Consider entering a **Technical Contact** for the person responsible for setting up electronic data exchange with public health.

Alternate Contact

Contact Name:

Contact Role:

Contact Email:

Contact Phone:

Contact Fax:

() - -

() - -

Electronic Health Record (EHR) Vendor

Vendor Name:*

If other:

Product:

Version:

Select From The List

Helpful Hint

The **Electronic Health Record Vendor** is a required section. Please include the product and version if available.

* indicates a required field.

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Next

Immunization Objective

Immunization:

Helpful Hint

The information on this screen should reflect the contact and vendor information only for the **Immunization Reporting** objective (though it may be the same as the other objectives).

Primary Organization Contact

Contact Name:*
Contact Role:*
Contact Email:*
Contact Phone:* () -
Contact Fax: () -

* Primary Organization Contact will be the individual who receives all official communication from VDH.

Technical Contact

Contact Name:
Contact Role:
Contact Email:
Contact Phone: () -
Contact Fax: () -

Helpful Hint

Primary Organization Contact (POC) is a required section. The POC will receive all official communication from VDH. Consider entering a **Technical Contact** for the person responsible for setting up electronic data exchange with public health.

Alternate Contact

Contact Name:
Contact Role:
Contact Email:
Contact Phone: () -
Contact Fax: () -

Electronic Health Record (EHR) Vendor

Vendor Name:* Select From The List
If other:
Product:
Version:
ONC Certified Number:
HL7 Version:

Helpful Hint

The **Electronic Health Record Vendor** is a required section. Please include the product and version if available.

* indicates a required field.

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Next

Syndromic Surveillance Objective

Helpful Hint

The information on this screen should reflect the contact and vendor information only for the **Syndromic Surveillance** objective (though it may be the same as the other objectives).

Syndromic Surveillance:

Primary Organization Contact

Contact Name:*
Contact Role:*
Contact Email:*
Contact Phone:*
Contact Fax:

* Primary Organization Contact will be the individual who receives all official communication from VDH.

Technical Contact

Contact Name:
Contact Role:
Contact Email:
Contact Phone:
Contact Fax:

Helpful Hint

Primary Organization Contact (POC) is a required section. The POC will receive all official communication from VDH. Consider entering a **Technical Contact** for the person responsible for setting up electronic data exchange with public health.

Alternate Contact

Contact Name:
Contact Role:
Contact Email:
Contact Phone:
Contact Fax:

Electronic Health Record (EHR) Vendor

Vendor Name:* Select From The List
If other:
Product: 
Version: 
ONC Certified Number: 

Helpful Hint

The **Electronic Health Record Vendor** is a required section. Please include the product and version if available.

* indicates a required field.

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Next

Registration Review

Helpful Hint

Once **Contact** and **Vendor** information is supplied for all objectives that were selected, a final Registration Review page is the last step before submitting registration.

Please review and click “Submit” button at the bottom of the page to complete registration. Click “Edit” to modify information entered in the registration form. If you would like to add another objective you must click “Edit” for the “Practice Information” section.

[Expand All Sections](#) | [Collapse All Sections](#)

Practice Information

Health Care System:	None	MU Stage:	Stage 1
Practice Name:	Test Practice - Richmond	Attestation Year:	1
Practice Type:	Family Medicine	Reporting Begin Date:	09/01/2013
NPI Number:		Reporting End Date:	09/15/2013
Incentive Program:	Medicare		

Helpful Hints

Review each section for accuracy and completion. If anything needs to be modified or added, click **Edit** for the respective section to make these changes.

Practice Locations

Name	Street	Zip Code	City	County/Independent City	State	Edit
Test Location - Richmond	123 Main Street	23219	RICHMOND	CITY OF RICHMOND	VA	

Eligible Professionals

First Name	Last Name	Middle Name	NPI Number	Edit

Cancer Reporting

Contact And Vendor Information:

Contact Name	Role	Email	Phone	Fax	Edit
Test Contact	Office Manager	test@test.com	(123) 131-3133	() - -	

Vendor Name	If Other	Product	Version
Other EHR Not Listed			

Syndromic Surveillance

Contact And Vendor Information:

Contact Name	Role	Email	Phone	Fax	Edit
Test Contact	Office Manager	test@test.com	(321) 313-1313	() - -	

Vendor Name	If Other	Product	Version	ONC Certified Number
Other EHR Not Listed				

Immunization

Contact And Vendor Information:

Contact Name	Role	Email	Phone	Fax	Edit
Test Contact	Office Manager	test@test.com	(132) 131-3131	() - -	

Vendor Name	If Other	Product	Version	ONC Certified Number	HL7 Version
Other EHR Not Listed					

Helpful Hint

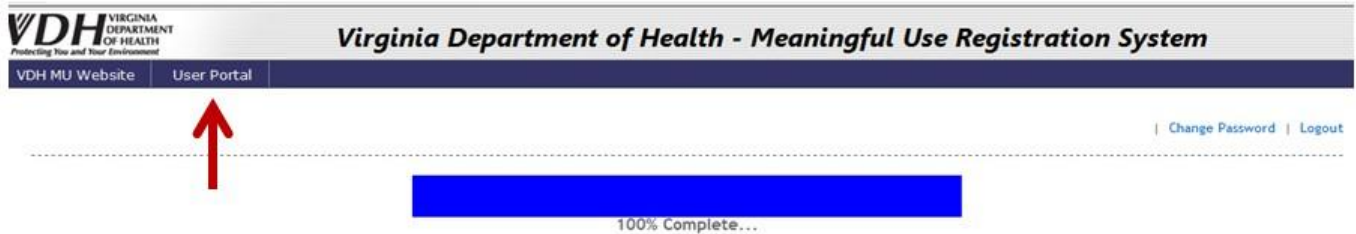
If all information is correct and complete, click **Submit** at the bottom of the page to complete the registration.

Submit

Registration Confirmation

Helpful Hints

Once you hit **Submit**, the MU Registration System will indicate your successful registration and a confirmation email for each registered objective will be sent to the relevant Primary Organization Contact and any other contact provided on the registration form. The confirmation email will contain a unique **Registration ID** so you can track the status of your submitted registration.



Registration has been successfully submitted to the Virginia Department of Health. A confirmation email for each registered objective will be sent to the email address listed under the Primary Organization Contact on the registration form.

To register another Eligible Hospital or Eligible Professional, please navigate to the User Portal using the link at the top left.

Helpful Hint

To register another professional, or check the status of your submitted registration, click on **User Portal** at the top left.

Once a registration has been successfully submitted to VDH, your status will be "Registered".

The VDH Meaningful Use statuses in order are:

- Registered
- Invited to Onboard
- Testing and Validation
- In Production

To ensure VDH has documentation of your progress towards ongoing data submission, a new registration is required for each attestation year.

Eligible Professional Checklist

The check list below outlines the information needed by Eligible Professionals to complete a registration form through the Virginia Department of Health Meaningful Use Registration System.

Eligible Professional (* denotes required information)		
Practice Information		Complete? <input checked="" type="checkbox"/>
Practice Name*	Enter the full business name of the practice. Do not use any abbreviations.	<input type="checkbox"/>
Health Care System*	Select the organization to which the hospital belongs (i.e., is owned by or managed). If organization is not listed select "Other Organization Not Listed" and enter name of organization.	<input type="checkbox"/>
Group NPI	10-digit National Provider Identifier issued by Centers for Medicare and Medicaid Services (CMS).	<input type="checkbox"/>
Practice Type*	Select the type or specialty of the practice. If the type or specialty is not listed select "Other Practice Type Not Listed" and enter the type of practice.	<input type="checkbox"/>
MU Stage*	Select the stage of Meaningful Use for which the practice is attesting.	<input type="checkbox"/>
Attestation Year*	Select the year of Meaningful Use for which the practice is attesting.	<input type="checkbox"/>
Incentive Program*	Select the EHR Incentive Program for which the practice is attesting.	<input type="checkbox"/>
Reporting Period Begin Date*	Enter the first date of the reporting period. If a reporting period has not been established please estimate date.	<input type="checkbox"/>
Reporting Period End Date*	Enter the last date of the reporting period. If a reporting period has not been established please estimate date.	<input type="checkbox"/>
Objective Selection (Must select at least one objective)		
Cancer Reporting		<input type="checkbox"/>
Syndromic Surveillance		<input type="checkbox"/>
Immunization		<input type="checkbox"/>
Practice Location (Must enter at least one location)		
Location Name	Please provide at least one location. If there are multiple locations for this practice please list each location. The location name can be the same as the practice name	<input type="checkbox"/>
Street	Street address where the practice is physically located.	<input type="checkbox"/>
Zip Code	Zip code in which the practice physically located.	<input type="checkbox"/>
City	City in which the practice is physically located. Field will be populated based on Zip Code entered.	<input type="checkbox"/>
County/Independent City	County or independent city in which the practice is physically located. Field will be populated based on Zip Code entered.	<input type="checkbox"/>

State	State in which the practice is physically located. Field will be populated based on Zip Code entered.	<input type="checkbox"/>
Eligible Professionals (<i>Must enter at least one professional</i>)		
First Name		<input type="checkbox"/>
Middle Initial		<input type="checkbox"/>
Last Name		<input type="checkbox"/>
NPI Number	10-digit National Provider Identifier issued by Centers for Medicare and Medicaid Services (CMS).	<input type="checkbox"/>
Electronic Health Record (EHR) Vendor		
EHR Vendor Name*	Select the EHR vendor used to meet Meaningful Use. If vendor is not listed select "Other EHR Not Listed" and enter name of vendor.	<input type="checkbox"/>
EHR Vendor Product	Enter the EHR vendor product used to meet Meaningful Use.	<input type="checkbox"/>
EHR Product Version	Enter the version of the EHR product.	<input type="checkbox"/>
ONC EHR Certified Number	Found here: http://oncchpl.force.com/ehrcert?q=chpl	<input type="checkbox"/>
HL7 Version	Select version of HL7 that will be sent to public health. (<i>Immunization Only</i>)	<input type="checkbox"/>
Primary Organization Contact		
Contact Name	Primary organization contact is required and will be the individual who receives all official communication information from VDH.	<input type="checkbox"/>
Contact Role		<input type="checkbox"/>
Contact Email		<input type="checkbox"/>
Contact Phone		<input type="checkbox"/>
Contact Fax		<input type="checkbox"/>
Technical Contact (Optional – if entered, * denotes required information)		
Contact Name	Individual responsible for setting up electronic data exchange (e.g. integration analyst, EHR vendor)	<input type="checkbox"/>
Contact Role		<input type="checkbox"/>
Contact Email		<input type="checkbox"/>
Contact Phone		<input type="checkbox"/>
Contact Fax		<input type="checkbox"/>
Alternate Contact (Optional – if entered, * denotes required information)		
Contact Name		<input type="checkbox"/>
Contact Role		<input type="checkbox"/>
Contact Email		<input type="checkbox"/>
Contact Phone		<input type="checkbox"/>
Contact Fax		<input type="checkbox"/>